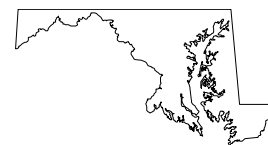


# ORAL HEALTH



## Focus Area 1 - Reducing Oral Cancer Mortality

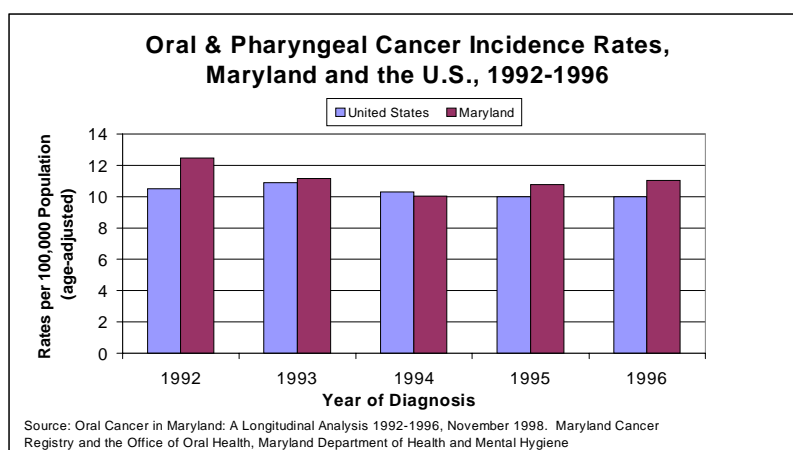
### Definition

Oral and pharyngeal cancers include the following sites: lips, oral cavity and pharynx. Rates are expressed by the incidence (number of new cases) per 100,000 population or the mortality (number of deaths) per 100,000 population.

### Problem

Oral cancer is the forgotten cancer. Each year oral cancer takes more lives than cervical cancer, Hodgkin's disease and malignant melanoma. The five-year survival rate for persons diagnosed with oral cancer is 52% – a survival rate that has not improved over the past 16 years.

From 1992 to 1996, the number of new oral cancer cases in Maryland was higher than the national rates for four out of the five years studied. Maryland ranks *seventh* among the states and the District of Columbia in mortality from oral cancer – sixth for males and females (national cancer SEER data, age-adjusted from 1992-1996).



### Determinants

Maryland's oral cancer mortality rate between 1992-1995 was 17.9% *higher* than the national rate. The use of tobacco products and alcohol are the primary risk factors contributing to oral cancer. Other causes of oral cancer include lack of fruit and vegetables, iron deficiency anemia, DNA viruses, and exposure to ultraviolet rays. Approximately 75% of oral cancer cases in the U.S. can be attributed to tobacco use. In Maryland, a longitudinal case study from 1992-1996 found that 81% of reviewed cases used tobacco and 51.5% were using tobacco at the time of diagnosis. These figures are substantially higher than the 1994 estimated smoking prevalence of 20.1% among Maryland adults.

Possible reasons for Maryland's high mortality rates of oral cancer are 1) lack of early detection; 2) lack of access to healthcare; 3) high levels of both chewing and smoking tobacco use; and 4) genetic predisposition.

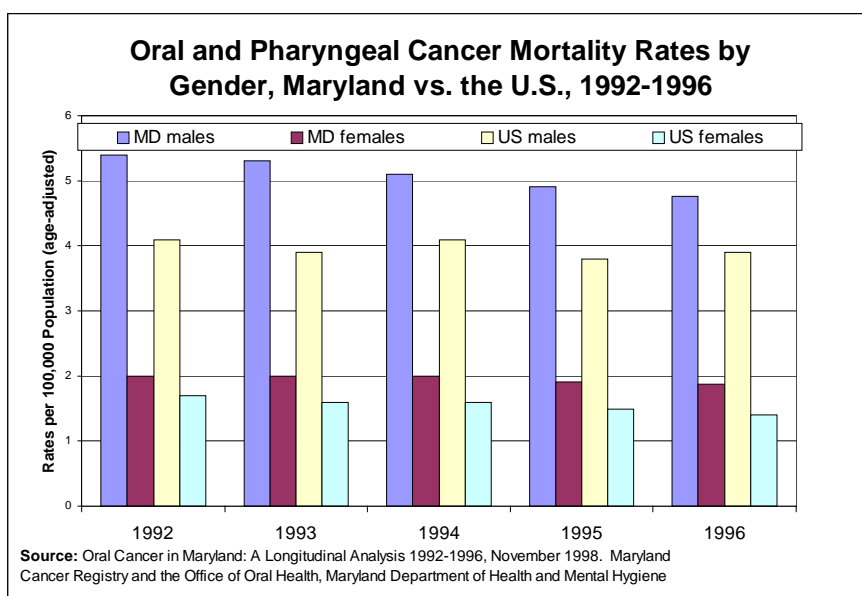
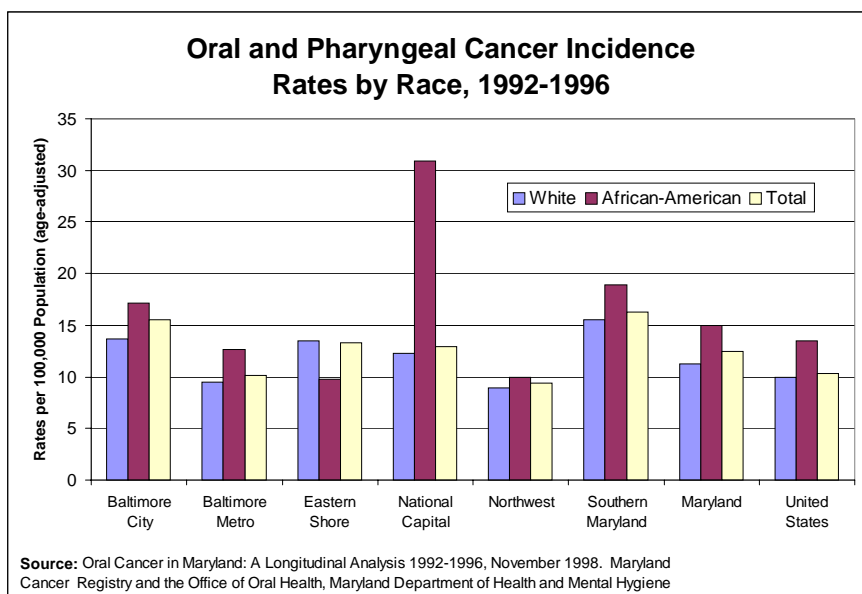
## Oral Cancer and Health Disparities

In the United States and in Maryland, African-Americans have higher incidence and mortality rates than whites. African-American men have the highest incidence of oral cancer and suffer the lowest survival rates of any other racial or ethnic group. This disparity likely exists because of limited access to treatment, and limited knowledge of oral cancer and the importance of early detection and screening.

Nationally, among African-Americans, oral cancer is the fourth most common cancer and the seventh leading cause of cancer death in African-American men. Only 34% of African-Americans diagnosed with oral cancer survive five or more years, compared with 55% of whites.

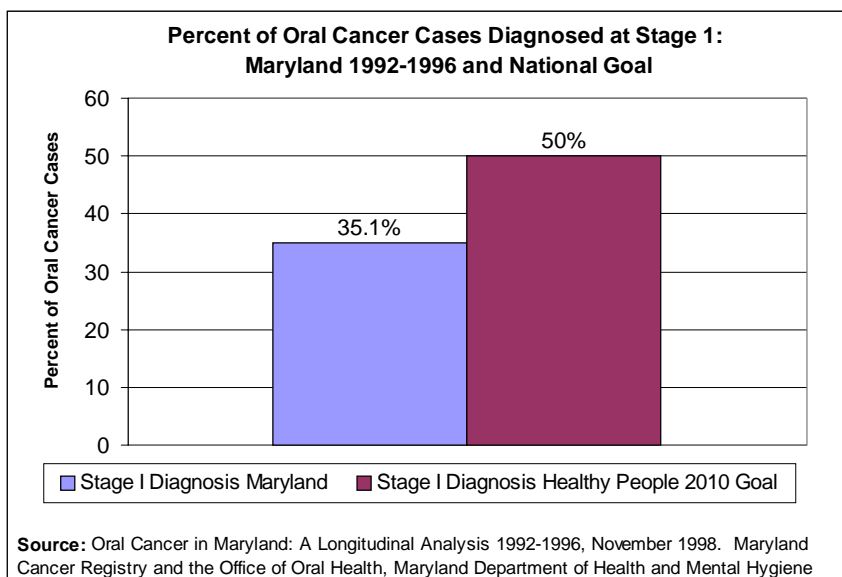
Nationally, African-Americans are diagnosed with oral cancer 10 years earlier than in the general population where the disease is normally diagnosed between the ages of 65 and 74. Maryland follows this national trend with the median age at diagnosis among whites being 65 and among African-Americans 57. Whites represent 72% of oral and pharyngeal cancer cases in Maryland, African-Americans represent 24% of cases, and 4.2% are other races. While African-Americans represent only 24% of the total Maryland cases, they are disproportionately represented among the number of patients with advanced disease, a trend that is also observed nationally.

Analysis of 1992-1996 oral cancer registry data revealed that Baltimore City had a statistically higher incidence rate than national data. Oral cancer mortality rates among African-American men in Baltimore City and Prince George's County were also significantly higher than the national average.



From 1992-1996, 585 Maryland residents died of oral and pharyngeal cancer. The figure on the previous page shows that for these five years Maryland men and women had higher mortality rates than the national rates.

Oral cancer is also associated with low socio-economic status, urban residence and social instability – all factors highly correlated to tobacco and alcohol use and poor health care. In Maryland and elsewhere, those at highest risk of oral cancers are generally not covered by private or public health insurance aimed at ensuring an annual oral cancer exam.



The decline in risk of oral cancer following the cessation of smoking or chewing tobacco, at any stage of disease and irrespective of the number of years of using tobacco, is rapidly providing evidence of the importance of quitting.

**Objective 1** - By 2010, increase to at least 50% the proportion of oropharyngeal cancer lesions detected at Stage I (localized). (Baseline: 35.1%, detected at Stage I)

**Objective 2** - By 2010, increase to at least 50% the number of adults, aged 40 years and older, who, in the past year, reported having had an oropharyngeal cancer examination. (Baseline: 20%, from 1995 data collected in Maryland by the National Institute of Dental and Craniofacial Research)

### Action Steps

- ⇒ Implement an educational campaign for dental and medical providers in Maryland so that they are knowledgeable about oral cancer risk behaviors and populations and understand the importance of and feel confident conducting an oral cancer exam.
- ⇒ Increase the number of dental providers accepting Medicaid patients.
- ⇒ Implement an oral cancer campaign encouraging individuals at risk to be screened for oral cancer.

## Partners

Center for Cancer Control and Surveillance, DHMH • Managed Care Organizations • Maryland Chapter of the American Cancer Society • Maryland Dental Hygienist's Association • Maryland Dental Society • Maryland Local Health Departments • Maryland Medicaid • Maryland State Dental Association • National Institute for Dental and Craniofacial Research • Office of Oral Health, DHMH • University of Maryland Dental School

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## Focus Area 2 - Preventing Oral Disease in Children

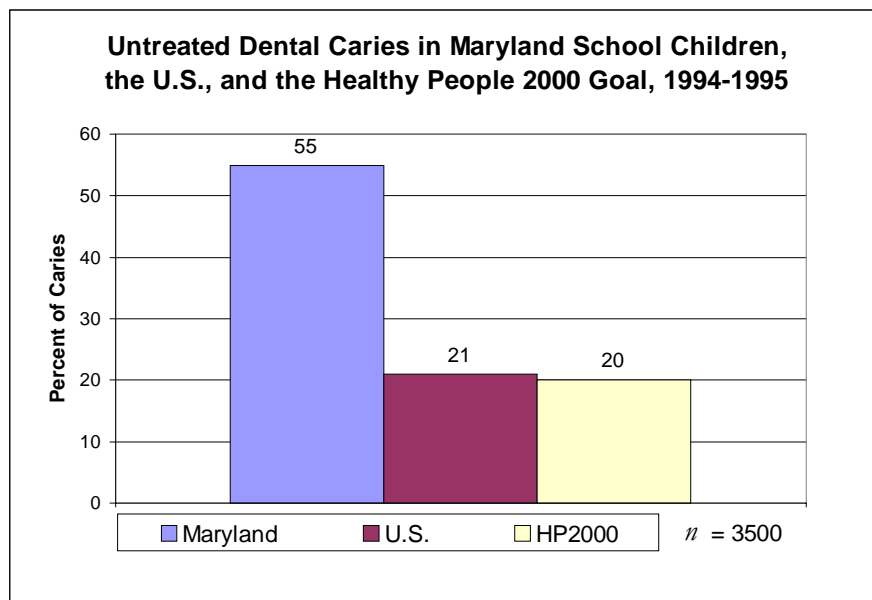
### Definition

Oral disease in children includes tooth decay, periodontal (gum) disease, broken teeth and jaws, other conditions from abuse or accidents, and developmental diseases, including cleft lip and cleft palate. In millions of children, these untreated dental conditions cause unnecessary pain and swelling making it difficult to eat or speak and possibly contribute to a failure to thrive. Their appearance may cause embarrassment and diminished self-esteem. Children who have decay in their primary (baby) teeth are more likely to develop decay in their permanent teeth. New research indicates that decay in adult teeth may lead to cardiac and obstetric complications.

### Problem

Preventable oral disease afflicts the majority of American children. In the United States 25% of children and adolescents experience 80% of all dental decay. Children whose families have low incomes, are in minority groups, have minimal exposure to fluoride, have special health needs, or come from less educated or poorer families are at greatest risk for oral disease. In 1995, fewer than one in five children in the United States who were eligible for dental services under Medicaid/ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program received a preventive dental service.

National studies reveal that individuals with the greatest need for oral health services are those least likely to have dental insurance or the personal resources to purchase dental care. A 1996 study of the U.S. Medicaid population found that 2% of children, ages five years and under, used 35% of all resources spent on dental care. These high costs were mostly for treating severe cases of early childhood caries (baby bottle tooth decay) in a hospital setting – a fundamentally preventable oral disease.



**Source:** Survey of Oral Health Status of MD School Children, 1995. Dept. of Pediatric Dentistry, University of Maryland at Baltimore, Dental School and the Office of Child Health, Maryland Department of Health and Mental Hygiene. School Children in grades K,3,6,9,12.

## Determinants

The oral health status of children in Maryland mirrors that of the nation. In 1993, only 14.2% of Medicaid eligible children in Maryland received EPSDT preventive dental services.

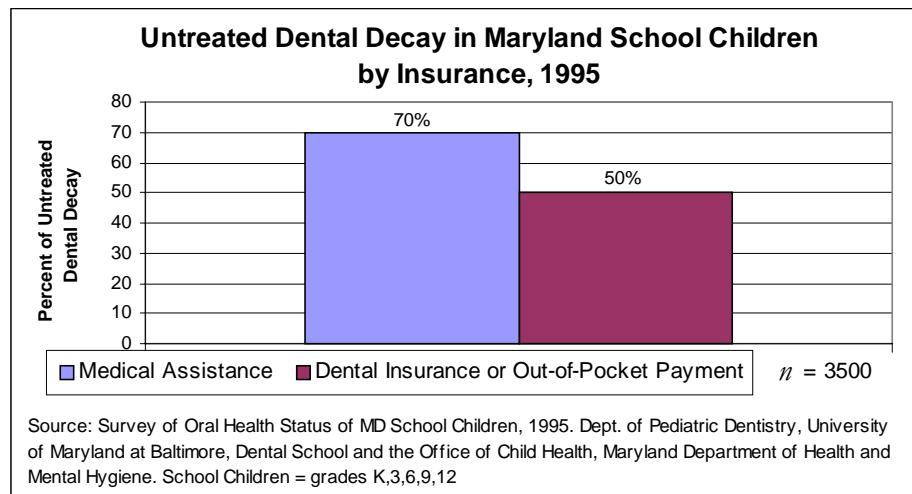
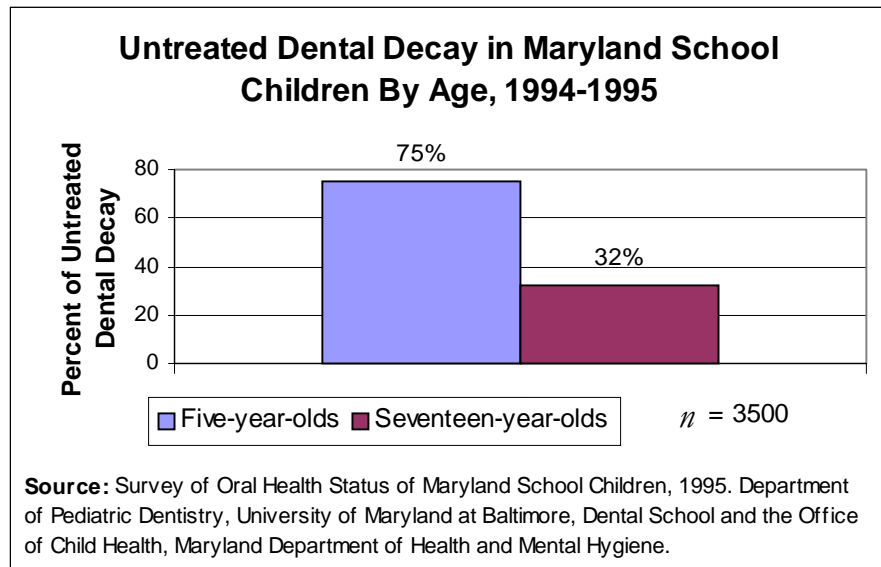
The Survey of the Oral Health Status of Maryland School Children, 1994-1995 found nearly three times the U.S. average in untreated tooth decay. Seventy-five percent of this untreated decay was found in five year olds versus 32% of untreated decay found in 17-year-olds. This same study revealed that 50% of Maryland kindergarten children had decay and those children who were eligible for Medicaid or free/reduced school lunch programs had 30% more decayed teeth. Children living in areas without fluoridated water had 50% more decayed teeth than children living in areas with fluoridated water.

Dental caries (cavities) are the most common oral disease in children. This infectious disease starts before the eruption of the first tooth and continues through one's life. Dental caries have a strong link to poor feeding practices, nutrition, and oral hygiene.

## Disparity in Access to Quality Oral Health Care

For children receiving Medicaid, access to dental care is difficult. The 1994 – 1995 Survey of the Oral Health Status of Maryland School Children found only 33% of Medicaid-eligible children visited a dentist every six months compared to the State average of 48% of children who saw a dentist every six months. Children who received Medicaid had 70%

untreated decay versus 50% of untreated decay in children who had private health insurance or paid out of pocket. The results of this study also showed that 75% of decay was in 25% of the children and, even more startling, that 15% of the children had 50% of the decay.



Western Maryland suffered the most with having both the highest number of cavities per child and the highest percentage of children with cavities. The Eastern Shore was the second most affected area in Maryland having the same oral health problems. The oral disease that exists in these two areas of the State is mostly due to a lack of access to dental professionals and lack of community water fluoridation.

**Objective 1 -** By 2010, increase dental reimbursement rates to help meet the dental services utilization goals established in 1998 by Senate Bill 590.

**Objective 2 -** By 2010, increase the number of children with sealants by 20%. (The baseline number will be taken from the 2000-2001 Oral Health Survey of Maryland School Children that will be conducted by the University of Maryland, Dental School.)

**Objective 3 -** By 2010, reduce untreated cavities in the primary and permanent teeth by 20%. (The baseline number will be taken from the 2000-2001 Oral Health Survey of Maryland School Children that will be conducted by the University of Maryland, Dental School.)

### **Action Steps**

- ⇒ Increase provider participation in Medicaid by increasing reimbursement rates.
- ⇒ Organize partners to help develop a mechanism to increase public awareness about the importance of oral health particularly in underserved and high-risk populations.
- ⇒ Increase the number of effective school-based or school-linked sealant programs for targeted high-risk children.
- ⇒ Link with current School Based Health Centers to provide preventive oral health services and referrals to dental providers.
- ⇒ Increase the number of public facilities able to provide oral health services to individuals in need.
- ⇒ Improve oral disease surveillance by sampling four counties every other year and every fifth year by conducting a statewide survey.
- ⇒ Develop and promote oral health initiatives through established programs such as the Maryland State Women, Infant, and Children (WIC) Program, Head Start, Maryland State Office of Child Health, etc.

# Partners

Advocates for Children and Youth • Centers for Disease Control and Prevention • Head Start • Managed Care Organizations participating in HealthChoice • Maryland Academy of Pediatric Dentistry • Maryland Dental Hygienist's Association • Maryland Dental Society • Maryland Local Health Departments • Maryland Medicaid • Maryland Office of Children, Youth and Families • Maryland State Women, Infant, and Children (WIC) Program, DHMH • Maryland State Dental Association • National Institute for Dental and Craniofacial Research • Office of Child Health, DHMH • Office of Oral Health, DHMH • University of Maryland Dental School

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